DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
OPERATIONAL POLICY LETTER #114
OPL2000.114

Date: January 27, 2000

Subject: Reporting Appeal and Quality of Care Grievance Aggregate Data to Beneficiaries Upon Request

Effective Date: January 1, 2000

NOTE: In accordance with 5 CFR section 1320.5(b)(2)(i), M+C organizations (M+CO) are required to comply with the requirements of this OPL when HCFA displays the OMB control number 0938-0778.

Background:

This operational policy letter (OPL) complements OPL 99.081, issued February 10, 1999, which provided guidance on the manner and form that M+COs must disclose appeal and grievance data to eligible Medicare beneficiaries upon request. This requirement can be found in section 1852 (c)(2)(C) of the Social Security Act and part 422 CFR (42 CFR section 422.111(c)(3)). As promised in OPL 99.081, the Health Care Financing Administration (HCFA) conferred with representatives from M+COs, consumer advocacy groups and communication specialists to develop general guidance and instruction to accompany data reports (See Attachment A). One of the primary concerns expressed by both the advocacy community and industry officials was the need for M+COs to be able to explain what the data might indicate. In an effort to provide guidance to M+COs, HCFA has developed a model for both presenting and explaining the appeal and (quality of care) grievance data (See Attachment A for the model appeals and quality of care grievance report, and Attachment B for the model explanation about the report).

Explaining Appeal and Quality of Care Grievance Data Reports:

As illustrated in Attachment B, M+COs should provide both contextual information and, where possible, offer an explanation about what the data might suggest. By doing so, M+COs will help beneficiaries to make a connection between the processing and disposition of appeals. For example, line 10 of the appeal data report (See Attachment A) requires M+COs to report the number or percentage of cases reviewed by the independent review entity, i.e., the Center for Health Dispute Resolution (CHDR), that were decided fully in favor of the enrollee. The report shows that of the 86 appeal cases that XYZ Organization forwarded to CHDR for review (See line 9), 16 or 19% were decided fully in favor of the enrollee. On page 4 of Attachment B, the report provides background regarding independent reviews. For example, one sentence explains that an independent review provides an opportunity for a new, fresh look at the appeal outside of the plan.

Also, in an effort to explain why the independent review organization might disagree with XYZ organization, the report offers that the independent review organization may have had more information about the appeal.

If M+COs format their reports according to Attachments A and B, M+COs will meet the disclosure requirements set forth in the M+C regulations at 42 CFR section 422.111(c)(3). **You may use the model reports or develop your own; however, you must include the content of every line item in the Attachment to OPL 99.081** (See also Attachment A). If you develop your own report, you must only include factual information and you must avoid including subjective statements such as "this is a low number of appeals for an M+CO." In addition, all reports must be approved by your HCFA Regional Office (RO) plan manager. Approval of a national plan's language will be approved by the lead RO in accordance with HCFA's marketing guidelines. While the HCFA RO approves the content of the report, the M+CO is solely responsible for the validity of the data included in the report.

Effective Dates:

The statutory requirement for reporting appeals and grievance data to beneficiaries upon request, is effective Jan. 1, 2000.

We recognize that M+COs will need time for RO approval of the language they will use to explain the context for their appeals and grievance data. Therefore--

1. If M+COs receive requests from beneficiaries for appeals and quality of care grievance reports between January 1 and March 24, 2000, M+COs should disclose data similar to or in the format provided in Attachment A.

2. M+COs must comply with the requirements for explanatory reports set forth in this OPL no later than March 27, 2000. Their explanatory reports must be approved by their RO plan managers on an initial, and then at least annual basis. For its initial approval, M+COs should submit their reports to the ROs no later than February 11, 2000. We have provided model language at Attachment B, that if used, will expedite timely approval of the M+CO's report by their respective ROs. Once M+COs receive this approval, they should follow-up with beneficiaries by providing their explanatory reports.

Attachments

Contact: HCFA Regional Office Managed Care Staff.

This OPL was prepared by the Center for Beneficiary Services.